# INDIANA STATE DEPARTMENT OF HEALTH
# ADOPTION HISTORY REGISTRATION PROGRAM
# BIRTH PARENT NONRELEASE FORM

State Form 46392 (R/5-01) IC 31-19-25-4

Name_____

Address_____

_____

Telephone Number_____

**CHILD'S BIRTH INFORMATION**

Child's Birth Name_____

Child's Date of Birth_____

Child's Sex_____

Child's Place of Birth_____

.....

This nonrelease form is to remain in effect for _____ years*. Date of expiration will be: ____/____/____
Month Day Year

*If this form is to remain in effect during your lifetime, indicate *99* years.

I wish to receive notice (90 days) prior to expiration:

( ) Yes

( ) No (If no is checked, identifying information will be released to the adult adoptee upon request after the expiration date.)

_____/_____
Signature Date

**THIS FORM MUST BE SIGNED AND DATED IN ORDER TO BE VALID**

**Send this Form To:**

**B-4**
**Indiana State Department of Health**
**Indiana Adoption History Registration Program**
**2 N. Meridian Street**
**Indianapolis In 46204-3006**